Prequalification Questionnaire for VA Driving Assignments				
DRIVER'S INFORMATION				
Van Driver Name	DOB	SSN		
Address		City/State		
Phone Number	Duty Location of Driver			
Problems with feet, hands and/or arms that may interfere with your ability to perform normal tasks associated with driving  Do you take insulin injections for diabetes?  Do you take oral diabetic medication?  Uncontrolled diabetes  Uncontrolled high blood pressure  Epilepsy (seizures), fits, convulsions, or fainting spells  Muscle weakness, decreased ability to move your limbs, or decreased coordination  A psychiatric disorder that could interfere with your ability to drive (nervous or emotional problems)  NOTE: Any yes answer will require a writte  * Signature required on reverse side of form	No Visual problems  Current or chronic use of a medication such as sedative relaxants, pain medication, anti-nausea, or anti-histami  Respiratory problems (such chronic asthma, emphysem dependence, or pulmonary)  Alcoholism (any history of alcoholism must provide documentation of being fold treatment program and of a for 1 year)  Drug abuse or dependence history of drug abuse, you provide documentation of lefollowed in a treatment proof abstinence for 1 year)	my drug/ es, muscle  mes  mes  as  a, oxygen blood clots)  f  lowed in a bstinence  (any must peing or lower extremity blood clots)  (any must peing or lightheaded episodes    Any of the following heart conditions     Recurrent or frequent chest pain     Pacemaker     Defribrillator     Aortic stenosis     Heart block     Dissecting aneurysm     History of coronary artery bypass surgery     Cardiac valve replacement surgery     Symptoms of other heart problems (such as shortness of breath)		

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Name:	SSN:	Date:
3 MEDICATIONS Indicate v	with a checkmark any medications you're currentl	y taking or have taken in the last month
Anticonvulsants	Diabetic medication(s)	Pain medication(s)
Antidepressants	Diuretics (water pills)	Recreational drugs
Asthma inhalers	Heart medication(s)	Steroids or cortisone
Beta blockers	Insulin	Thyroid medication
Blood pressure medication(s)	Migraine headache medication(s)	Sedatives or sleeping pills
Blood thinners	Muscle relaxants	Ulcer medications
Chemotherapy or radiation therapy	Over the counter medication(s)	
REMARKS		
5 I certify that this information is complete an	nd true: Signature of Applicant:	Date:
I certify that this candidate has been screene in accordance with the FMCSA Policy:	ed Print Name	gnature:
All VA Volunteer Coordinators comply with this po candidates are to report to the Employee Health offi	olicy. If this form is not completed and signed by both partie ce in Building 22, room 1B116 for the exam. For more info	